

FILED AUG 6 1943 130

Registration District No. 310

Primary Registration District No. 5463 A

Registrar's No. 18

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County GREENE
(b) City or town STRAFFORD
(c) Name of hospital or institution: R.F.D. #11
(d) Length of stay: In hospital or institution _____
In this community 59 yr. 11 mo. 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Greene
(c) City or town Strafford
(d) Street No. R.F.D. #11
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME THOMAS BURWELL
(b) If veteran, name war NONE
(c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 13th
year 1943 hour 3 minute 40 P.M.

4. Sex MALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife BERTHA BURWELL
6. (c) Age of husband or wife if alive 57 years
7. Birth date of deceased Aug 10 1883

21. I hereby certify that I attended the deceased from No Physician in attendance
that I last saw _____ alive on _____, 19____
and that death occurred on the date and hour stated above.

8. AGE: Years 59 Months 11 Days 3
If less than one day _____ hr. _____ min.

Immediate cause of death Intra-cranial Hemorrhage + shock
Due to Fracture of skull
Due to Fall from beam loft

9. Birthplace SPRINGFIELD MO. A

Other conditions High blood pressure
Major findings: 186 a
Of operations 1059
Of autopsy 21

10. Usual occupation FARMER

11. Industry or business FARMING.

12. Name LOUIS BURWELL

13. Birthplace ILL. A

14. Maiden name ELLEN HILTON

15. Birthplace ILL. A

16. (a) Informant Bertha Burwell

17. (a) Address Strafford Mo.
(b) Date thereof July 16 1943
(c) Place: burial or cremation Hazelwood Cem.

18. (a) Signature of funeral director W. H. Ingner H.C.
(b) Address Springfield, Mo.
(c) Date received local registrar 7/14/43
(d) Registrar's signature Harland Harrison

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident 1.39
(b) Date of occurrence July 13, 1943
(c) Where did injury occur? Greene Mo
(d) Did injury occur in or about home, on farm, in industrial place, in public place? On farm
While at work? Yes (Specify type of place) _____
(e) Means of injury Fall from height
23. Signature Murray C. Stone (M. D. or other) _____
Address Springfield, Mo Date signed 7-14-43

1246

RECEIVED

Greene County Health Office,

County File Number 43-8-85

Date Filed 8/4/43

MAR 3 1944

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed

J. B. Klingner

Licensed Embalmer No. 3358

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.